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ABSTRACT

The booklet considers principles of short-term group treatment to help parents of handicapped children with problems of emotional adjustment and child management. The value of a parents' group is seen to lie in the purposeful use of group dynamics and group processes by trained leader. Discussed are the role of the group leader; the process of selection including factors such as size of group, organizational setting, nature of the children's handicaps, and specific categories of parents; and group goals (primarily supportive in nature). Suggestions are given for managing the external structure of the group's dynamics in the areas of setting, number of meetings (12 to 15 sessions are recommended), spacing of meetings (weekly or biweekly), group size (10 to 15 members), and meeting time and place. Guidelines are offered for managing the internal structure of the group's dynamics in such situations as silences, direct questions, and expressions of hostility and for making the most of each phase of group development as well as positive and negative impact of group members on each other. Briefly discussed are parental concerns such as intense anxiety about the handicapped child's future. Listed are 23 suggested readings. (DB)

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GROUP TREATMENT

for parents of handicapped children

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GROUP TREATMENT FOR PARENTS OF HANDICAPPED CHILDREN

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INTRODUCTION

Group treatment, a technique currently used extensively for the alleviation of problems related to adjustment, is particularly well-suited to the task of aiding parents of handicapped children in the management of their problems.

This publication is concerned with group work with such parents. It is primarily directed to social workers and other professionals who are called upon to serve as leaders of parents' groups because of their assignment in clinics and programs for handicapped children, including the mentally retarded. However, it also may be useful to anyone engaged in helping handicapped children and their families. Many of the techniques presented can be adapted to other types of groups.

Parents of handicapped children represent a cross section of the U.S. population. Most of them manage their own lives fairly well until they learn that their child has a handicap. The diagnosis of a handicap—physical, mental, or emotional—can constitute a severe ego threat for parents and aggravate dormant problems or create new ones. However, parental reactions vary. Those whose children have physical handicaps are usually aware of the presence of a problem and can accept help to define it, while parents whose children have emotional problems often deny the existence of problems. Some parents of children with mental deficits acknowledge a handicap, but others do not.

Whatever the child's handicap, the needs of parents are for support, information, and assistance in child care and in management of their own emotions and social adjustment. Help in meeting these needs should be offered to parents while the child is young.

GENERAL CONSIDERATIONS

Approaches to group treatment, as well as theories, philosophy, and practice, vary considerably. One popular and effective approach to treatment for parents of handicapped children is the closed, short-term group.

Groups that serve these parents may be sponsored by a private or public clinic, hospital, mental health association, health or social service agency, or school. Groups are usually designed to augment the agency's comprehensive program for a handicapped child.

The parents' group is developed as a treatment tool for the relief of a problem situation. While all treatment is to some extent educational, the groups discussed here go beyond purely educational activities. Their specific value lies in the purposeful use of group dynamics and group processes by a trained leader. The goals are to help group members come to terms with their current situations, to facilitate their social adjustment, and to bring about changes in their self-images and ability to cope with problems.

A closed, short-term group usually consists of 10 to 15 people who meet regularly under the guidance of a group leader or therapist to achieve specific treatment goals during a prescheduled period of 3 to 6 months. The group is "closed" in the sense that the full membership is selected before the first meeting is held and additional members are rarely admitted later. These specifications are guidelines rather than rigid prescriptions. Size, time, setting, and other arrangements may be modified to take care of specific circumstances. Therefore, the closed, short-term group presents a particularly useful format for work with parents of handicapped children.

If members are carefully selected on the basis of personalities, problems, and treatment needs, the group will follow a fairly predictable course. There is flexibility within the group for both active and passive participation of each member during the course of the sessions. Members help each other through discussions that present diverse points of view and through sharing, and thus reducing, their own anxieties. Group pressure can be brought into play to curb unhealthy domination by an aggressive member, draw a timid one into a discussion, or encourage one with undeveloped leadership ability.

Compassion is always ego-strengthening; it is easily developed in a group setting and its effects transcend the consideration of child management.

The group structure intensifies treatment possibilities through the

mutual stimulation and mutual support that individual parents experience in the presence of other parents struggling with similar problems. Multiple relationships develop among the group members and between them and the leader; these relationships permit a kind of interplay that cannot be achieved in individual therapy. The relationships can be modified to meet the changing needs of individual members as well as those of the group as a whole.

THE GROUP LEADER

The position of a group leader differs considerably from the position of a therapist in an individual treatment situation. Status as a group leader carries with it authority and influence. At the same time the presence of a number of other people offers each member a kind of protection and dilutes both the intensity and the threat of treatment. As a result, a useful parity of control is established: the leader has more authority than any individual member, but members collectively influence each other and the group's progress as much or more than the leader.

The personalities, needs, problems, and treatment propensities of group members, group dynamics, and group movement all contribute to the complexity of the group and place great demands on the group leader. Work with groups, therefore, requires different training and skills than work with individual patients.

The skilled group leader, like a skilled artist, does not seem to exert any effort. This has sometimes led to the assumption that anyone who has attended a series of group sessions can step into the position of group leader—an assumption that is not supported by experience. When a treatment group is conducted by an untrained or irresponsible leader, the consequences are often disastrous.

Group leaders represent a variety of professional affiliations. They may be trained by members of any of the various professions within the mental health field. Often the training is on a graduate level.

The professional who has experience in working with mentally, physically, or emotionally handicapped children brings a special insight to the role of leader for this kind of parents' group.

There are basic skills without which no group leader can function. For example, every group leader must understand the phenomena that occur in group sessions. The leader needs insight into group methods, the differences in methodology between group and individual treatment, the effects of group attendance, basic dynamics of individual and group personalities, and how the same person may present himself differently in a one-to-one relationship and within a group. Implementation of group goals and protection of group function depend on the leader's awareness of the group as an integrated body. Because each member's standing within the group changes at different times and phases of treatment, the leader must recognize the effect that the group has on the individual as well as the effect the individual has on the group.

In work with parents of handicapped children, treatment methods are

primarily supportive and geared to improvement in coping and adjustment skills. Therapeutic intervention in group processes is a complex procedure. The skilled leader's sense of timing frees the group to develop and work toward goals at its own speed. Furthermore, the leader has to understand the meaning of silence and how to use it effectively. He has to know when silence is productive and should remain unbroken to permit recuperation after a stressful period, and when it is hostile and his intervention is required to help the group overcome a deadlock.

The leader's decision about whether to help the group become aware of the covert content of a discussion topic at a specific time depends on the readiness of the majority of members to face their own emotions, the possible reaction of vulnerable members, and a number of other circumstances.

The group leader's competence and authority should be clearly established at the initial interview with parents or at the opening session. Parents who join treatment groups are often confused and anxious about the diagnosis of their child's handicap and what it means. They respond more readily to the group setting when they know that the leader is an expert who can help them find some of the answers they want so desperately.

THE PROCESS OF SELECTION

In a treatment group every member is an active participant in helping every other member. Therefore, the size of the group, personality traits of the members, and variety of needs are important considerations in the selection of members and the setting of goals. Success hinges on carefully developed group composition as well as on the leader's understanding and skill in using the treatment process.

Careful selection of group participants is likely to speed up "group formation"—the sense of cohesiveness and identity that members develop through individual and group interaction during the course of the sessions.

In an ideal situation the leader himself makes the actual selection of group members on the basis of his interviews and diagnostic considerations. However, the choice is not always given to the group leader. Some sponsoring agencies, in the belief that selection by a leader or a staff team is discriminatory or stigmatizing, open treatment groups to all parents with children in a specific category. A school administrator, for example, may invite all parents of children enrolled in a special class to join the group, regardless of the parents' needs. Such groups, particularly when hastily formed or arranged by administrative decision that excludes the group leader from selection of members, are likely to peeter out.

Preparation of parents for entry into a group is an essential part of the dynamics of group treatment and requires the personal involvement of the leader. A letter of invitation is rarely sufficient to overcome the hesitancy of parents who genuinely want help but lack the confidence to try something new. Self-selection under such circumstances is primarily a negative process.

It is imperative, therefore, that the group leader obtain first-hand knowledge of prospective members. An initial interview with each candidate serves this as well as several other purposes. It permits the leader to explore a parent's suitability for the group and compatability with other group members. It familiarizes parents with group purposes and goals, enabling them to make an informed judgment about joining the group. It allows the leader to assess the needs of reluctant parents and decide whether to urge group membership or recommend some other form of help. It also gives members a chance to meet the leader and understand his philosophy and approach to problems, thus developing a common focus and mutual expectations for the group from its beginning.

Selection of members for a parents' group is influenced by a number of

factors which are listed below. It is the combination of these factors that determines the outcome of therapy for a specific group.

The Skill and Experience of the Leader. An expert leader is able to cater successfully to members with diverse needs. The leader's ability to reinforce healthy aspects of parents' personalities and deflect severe pathological behavior, which would otherwise disrupt group processes, determines the range of personalities that can be accommodated in a single group.

The Size and Composition of the Group. A group that has at least 10 to 12 members can accommodate one or two members with severe personality deviations more easily than a very small group. However, if a group is much in excess of 15 members, there is danger that members will form cliques or refuse to become involved in the group process.

The combination of the personalities within a group influences the members' ability to tolerate a confused or disturbed participant. Personality traits per se are neither conducive nor antagonistic to group membership. Two parents with the same trait—a strong need to control, for example—may neutralize each other in one group and support each other in another.

A fairly stable group can be immensely helpful by offering support to a troubled parent, by encouraging a dependent one to enter new activities, or by teaching an overactive one to relax. Under skilled leadership the group members may contribute to the healing and stabilization of a disturbed parent without becoming aware of the severity of his deviance.

The Organizational Setting. More often than is generally recognized, the sponsoring organization influences selection of group members through its administrative and therapeutic goals, which differ from organization to organization. The group that originates in a medical clinic may attract parents who look for medical solutions for their problems, while the school-based group may appeal to parents who are expecting to work on academic and intellectualized approaches. A group in a child guidance clinic may draw those who see their difficulties as stemming from emotional factors.

The expectations of the organizational setting affect the leader's selections as well as the selection of the leader.

The Nature of the Children's Handicaps. Many parents' groups are organized on the basis of the handicap that their children have in common. For example, one group may be open only to parents whose children are mentally retarded and another group only to those whose children are physically handicapped.

Specific Categories of Parents. Sometimes groups are formed to help a specific category of parents—fathers, mothers who are employed outside the home, or couples.

GROUP GOALS

Group goals for the closed, short-term parents' group are primarily supportive. These goals may be developed cooperatively by the group leader and group members.

The treatment goals usually incorporate the development and maintenance of adequate family and social functioning through identification of problem areas and the improvement of parental management of problems.

The group's main purpose is to enable parents to understand some of the general problems of handicapping conditions as well as the special problems of their own particular situation, so that they can work out more effective ways of managing the handicapped child and the rest of the family.

The group should offer parents some relief from external and internal pressures. Parents need assistance in learning how to safeguard their own physical and emotional health, in achieving some peace of mind, and in accepting their child's handicap. Or, if they cannot accept it, at least they must learn how to live with it.

Discussion of short-range as well as long-range plans for the handicapped child is an important group goal. This means discussion of techniques to develop self-help skills, school and vocational planning, and, if indicated, consideration of plans for living away from home.

There will be ample opportunity for focus on emotional aspects of situations and aid to parents in coming to terms with them.

Initially, parents of a handicapped child need to understand more clearly the normal patterns of development and behavior and general techniques of child management. This will enable them to differentiate between behavior that is a phase of every child's development, behavior caused by the child's disability, and behavior stemming from such parental attitudes as negative reinforcement, overindulgence, or rejection. Parents of the handicapped often need help in providing opportunities for growth and development for their healthy children as well as for the handicapped child.

GROUP DYNAMICS—THE EXTERNAL STRUCTURE

The Setting

The setting in which the group functions greatly influences group membership, as noted above, as well as expectations and reactions of group members and therapeutic approaches.

For example, in a psychiatric clinic the staff may consider group treatment a major tool and incorporate it as a part of administrative planning. In support of the concept of group treatment, the clinic provides adequate meeting rooms in which sessions can be held without interruption, schedules group meetings for parents as a part of the broad therapeutic program for patients, recruits a qualified leader for the group, and makes consultants available. In such a setting the leader and group members are influenced by the clinic atmosphere and emphasis will tend toward emotional components of the difficulties.

In contrast, a medical clinic may place a much lower priority on group treatment. Where space is at a premium even for medical services, the staff may not be able to provide a separate meeting room that would give the group the privacy and protection conducive to successful interaction. The medically oriented group may also reflect its setting by emphasis on the physical and organic aspects of the children's handicaps.

Group leaders and group members thus tend toward techniques, topics, and expectations fostered by the setting. It is the responsibility of the group leader to use external conditions constructively in the development of group structure and goals and, when necessary, to overcome the limitations of the setting. As a part of the external structure, each of the following conditions has an impact on the development of group dynamics.

Number of Meetings

Enough meetings must be held to allow the members to move through all phases of group formation (see Phases of Development, p. 17). A total of 12 to 15 meetings usually will meet this requirement and, in addition, help members reach some feeling of achievement.

In contrast to the open-end group, the short-term group makes use of the time limit as a part of its basic structure. This device serves as an impetus to group movement. The leader and the group members—equally aware that they have only a limited number of meetings scheduled—will

spell out goals more quickly and focus on the problems to be worked on much faster than a group without a definite termination date. The leader can determine how much time he must set aside from other duties to prepare for and conduct group meetings. Most parents can manage the added demands of group membership for a brief period. Babysitting arrangements for a handicapped child become less of a burden when the relative or neighbor who volunteers to help knows that there is a limit to the number of group meetings the parent will attend.

Spacing

Spacing of meetings is another important aspect of group dynamics. It influences the depth as well as the breadth of content, the density of group cohesion, and the long-range effect.

For a group designed to support parents of handicapped children, weekly or biweekly meetings seem to fill parental needs adequately. Either schedule allows good discussion and carryover of ideas from one meeting to the next. Anger or resistance aroused in one meeting can be worked through by the group in the following one. The period between meetings is long enough to give parents a chance to test new found knowledge, but short enough to clear up misunderstandings or misapplications before serious damage occurs.

If the interval between meetings is too long, the group loses its cohesion and dynamic impact. What is important in one meeting may seem out-of-place and artificial a month later. Disturbing material that emerged during a previous meeting cannot be handled constructively when the content is only vaguely remembered by group members.

Closely spaced meetings tend to intensify the group impact. Daily meetings or meetings that last 4 hours or more (as some group meetings now do) stir up deep-seated feelings without permitting individual members to adjust their defenses. Such telescoping of schedules is not appropriate for the parents considered here, although it may have its uses in groups geared toward personality reorganization.

Group Size

As mentioned earlier, a group size of 10 to 15 members seems most satisfactory for the parents considered here. Stability and group formation can be achieved fairly easily in a group of this size; the diversity among members adds to the group's viability and activity. The size also allows members to become aware of group interaction and the changes caused by irregular attendance so that absent members do not constitute a threat to continuity.

A very small group may be affected by the absence of a single member. And while it might seem that in a small group every member has to participate, full participation does not necessarily follow. A shy parent may

feel more exposed in a group of four or five than in a larger group in which he can count on some support and sympathy for his ideas.

Groups that are too large are likely to become so unwieldy and impersonal that members feel little responsibility for attending meetings, participating actively, or maintaining group function. There is also a danger of the development of strong, stable cliques that interfere with therapeutically helpful group processes.

If cliques form at all in a medium-size group, they are likely to be fluid and short lived, causing little disruption. A skilled leader sometimes may even want to use such cliques constructively.

Meeting Time and Place

The scheduling of meetings has a great impact on the parents' attitudes toward the group and its leader. The parents are likely to be under pressure in relation to the handicapped child, pressure that is often intensified by other members of the family. Arbitrary setting of the meeting time and place may add to the pressure.

The leader needs to be aware that there may be real obstacles for parents who want to attend group meetings. By taking into consideration such details as accessibility of the meeting place and parents' preferences regarding meeting time, the leader can demonstrate his willingness and ability to help troubled parents without having to tell them that he wants to help.

Coordination of mothers' and children's treatment programs can relieve many scheduling problems. It is often the handicapped child who requires special arrangements during the mother's absence. There are also other advantages to such scheduling. Parents relate closely to a setting in which their children receive help; they seem to feel less guilt about seeking help for themselves if their children are involved in treatment at the same time; and the agency can integrate child and parental therapy effectively.

Complaints about the meeting schedule should not be interpreted as resistance unless there is special reason to do so. If the meeting time is not convenient and the place is not easily accessible, much of the effect of therapy may be negated. For example, parents may be too exhausted to be receptive to the group process after they have struggled with an early supper for a school child, babysitting arrangements for the handicapped child, and rush-hour traffic.

The room in which the meetings take place should be conducive to group discussion. It should provide comfortable seating arranged in a circle or semicircle so that every member directly faces the group leader and other members. People in a back row of a standard classroom seating pattern are never as involved in the group process as those in a circle. If possible, the same meeting room should be used for all meetings in the series.

The importance of permanent furniture arrangements in rooms used for group treatment has been somewhat overemphasized in the literature. While replacement of a picture or relocation of a desk may throw psychotic patients into a panic, it receives no more than cursory attention from the average parent in the kind of group considered here. Even a somewhat disturbed parent takes his cue from the rest of the group and accepts changes of furniture or even meeting rooms in stride.

A treatment group inaugurated for parents of handicapped children several years ago illustrates this point. It was not possible initially to assign this group to a permanent meeting place. In succession members met in a music room where children walked in to get instruments, on a stage where the janitor stored chairs, and in a lounge adjoining the coffee machine. The group members became so involved in the treatment process that they accepted all interruptions and changes that occurred, waited for the outsiders to leave, and went right back to the business at hand. When the administration finally assigned a permanent meeting room, the group interpreted the action as both recognition and approval. Not all groups, however, can be expected to be so flexible; many in similar circumstances might have reacted by withdrawal.

GROUP DYNAMICS—THE INTERNAL STRUCTURE

Group Management

The therapeutic effectiveness of the group depends on the skills of the group leader; the use he makes of group composition; the physical setting; the active as well as passive reactions of group members; and incidental events that occur during the meetings. Areas of intervention that are of particular importance in the management of a parents' group include the opening phase of each group meeting (especially the first meeting), silences, direct questions, and hostility. These facets are handled according to diagnostic considerations, group purposes, and group goals.

Opening Phase. The leader may open the meeting with a simple, neutral remark to put group members at ease. For example, he may start the first meeting by suggesting that the members discuss what they understand the purpose of the group to be and what they expect of it. In later meetings he may build on pre-meeting chatter or offer a comment on the liveliness of the previous meeting. This does not mean that he chooses the topic for the group, however. It is important for the group leader to demonstrate his interest in the members from the opening session on.

Silences. In American culture, silences that are primarily the result of social awkwardness create discomfort within a group. It is the responsibility of the leader of a therapeutic group, at least initially, to put group members at ease during such silences. Premature focus on silence as resistance or precipitous interpretation of it as hostility may have a detrimental influence on the development of the interaction that would put group members at ease and start them to work on their problems.

If initial silences continue after several meetings, the leader may help the members explore the reasons for their reticence. In a parents' group, as in all therapy, the leader uses a differential approach to match his method and technique to the group's need.

Silences that occur naturally during meetings as part of the treatment process are dynamically different from those that occur at the beginning of a meeting. A prolonged silence, for example, may follow a discussion of significant ideas while group members mull over what they have just talked about. They may use the silence constructively to try to handle their own reactions and to decide their next moves. If the leader is relaxed about such a silence, the group will pick up the threads when it

is ready. If the silence is caused by resistance to the leader or to the topic under discussion, however, the group needs to be helped to work this through as part of the therapeutic process.

One incident in a mothers' group may illustrate the dynamic use of silence. This short-term group was composed of mothers whose handicapped children had been referred to a special clinic. After several meetings at the clinic, the mothers began to be aware of their own contributions to their children's behavior difficulties.

One day Mrs. T. spoke about her inability to control her young son's constant demands for snacks. Then she asked the group leader: "Should I give him all this junk? You tell me what to do and I will do it."

Here is a condensed version of the ensuing discussion:

Leader: "Would you really, just because I say so?"

Mrs. T.: "Yes, I would."

Leader: "But you just said yourself that all this junk is not good for Timmy. Why haven't you stopped giving him snacks on your own? What difference would my telling you make? Remember when Mrs. K. became unhappy with me for interfering with her method of toilet training? She felt she had been doing quite well until I suggested that she stop spanking her boy."

Mrs. K.: "That's right. But when we talked about my son's feeding himself, you suggested what to do—and it worked."

Leader: "It did? Why?"

Mrs. K.: "Oh, I was ready for that."

The leader permitted a silence to develop. It continued for a minute or two.

Mrs. T. (thoughtfully): "You mean that when I am ready to do something about my son's snacking problem, I will be able to handle it like Mrs. K. did?"

The mothers then were ready to discuss how confusing premature advice can be, why the group leader did not dispense advice freely, how members of the group could help each other, and how they themselves needed to understand their own problems before they could work out acceptable solutions.

Mrs. T. started to talk about her own contributions to her son's misbehavior. Several members of the group said they realized for the first time that they responded differently to their handicapped child and to their other children. They tried to understand the reasons for this.

These mothers had begun to realize some of the dynamics of relationships between themselves and their children and to understand how their group worked. They no longer resented the fact that the leader was not giving advice freely.

Direct Questions. Questions need to be handled with discrimination, according to specific needs of the group. In the past, leaders often mechanically turned back questions to the group member who asked

them. Today there is increasing acceptance of the concept that—even in a treatment relationship—there are times when people need to be given the answers or information they request.

To the parents of handicapped children, it is particularly important to have questions answered and requests for information met. Their need for information cannot easily be separated from the treatment process. Often, after the need is satisfied, a group is able to move forward to explore the underlying facets of the question.

The leader may not answer a question as soon as it is raised unless he understands its overt as well as its covert implications. Instead of a direct answer, he may stimulate group discussion to clarify the various parts of the question. This often will provide a partial answer on which he can build. It will also offer group members some insight into the underlying dynamics of their own "simple" need for information.

The timing and phrasing of a question also influence the leader's response. The questions may be "What is the purpose of this group?" and "What is your background?" If such questions occur at the beginning of a series of meetings, the leader answers simply and directly. But if the same questions come in the middle of the series, the leader may consider them a challenge or an indication of resistance. He then needs to find out what is causing the member's dissatisfaction.

Hostility. Parents may have a great deal of personal anxiety and hostility to handle in the early stages of group formation. The leader needs knowledge of group techniques to manage such hostility constructively—knowledge that he acquires through training and practice.

One theory of group management holds that group members should be responsible for starting their own meetings and the leader should wait silently and passively until the process occurs. The advocates of this theory state that the hostility and resistance created by the leader's refusal to help the group get started will provide the impetus for the members to begin to get the group started on its own initiative. Use of this approach seems to be of questionable value in a short-term group: parents who are not aware of the complex group process need a leader's guidance to become fully involved. Development of parental abilities and positive attitudes are goals of—not prerequisites for—group treatment.

To increase the parents' frustrations artificially before they are ready to face their own feelings can have a detrimental effect on the group process. Techniques that create anger are more likely to reassure the leader of his control over the members than to serve a constructive purpose for the group.

An example from a mothers' group illustrates the effects of hostility and resistance on group members.

The group consisted of mothers whose handicapped children of elementary school age attended special classes. Almost from its beginning, the group was split in two.

There were mothers who acknowledged that their children had physi-

cal and emotional problems. These mothers expected the group meetings to offer them help in planning and managing their children's behavior and ease their own heartache. There were a few mothers who were quite defensive about their children and therefore hostile toward the group. Mrs. M., who was particularly resistant, exerted a strong negative influence on several of the other mothers, and they became more hostile as the sessions progressed.

The group had other problems, too. One teacher openly questioned the value of the group. Attendance at group meetings was irregular, partly because of the resistance of some mothers and partly because of illness in the families of others. This, in turn, undercut whatever slight possibilities there might have been for group formation and continuity of content.

The group leader therefore decided to bring the group to a close somewhat earlier than she had originally planned. At the final meeting she asked the mothers to try to identify the group's problems. This, she hoped, might enable some mothers to use future help successfully. She focused the discussion on the members' hesitancy to become involved.

Mrs. M. said that she resented having to come. The group leader explained that there had never been any compulsion for parents to enroll in the group. The series had been offered because experience had shown that this kind of group could be quite helpful to parents of handicapped children.

Mrs. M. immediately said that she had never seen any reason for the group, adding that she could be much more helpful by spending time with her daughter than by attending meetings. And, she argued, discussing another child's eating problems would not help her daughter who did not have the same problem.

The group leader pointed out that eating problems are quite common in handicapped children and therefore are a good starting point for a general discussion. "What we actually discussed was the whole area of management of problems—not merely one child's eating habits," the leader explained.

At this point Mrs. R., one of the more perceptive members, said that she felt some of the mothers had deliberately undermined the group by detaching themselves from the rest who were serious about learning to handle their problems. She spoke emotionally about the heartache of knowing that she had a handicapped child. She had hoped that the group would offer her an opportunity to talk to other mothers about their feelings and the ways they managed these feelings, their children, and their families. At times, she continued, it was difficult to know how to react to her child's behavior. She often indulged him because she did not know what else to do.

The group leader commented that many parents indulge a handicapped child. "It is not easy to sort out what part of the child's behavior is a result of his illness and what part is caused by parental indulgence.

This is the kind of problem with which groups like ours hope to help parents," she added.

Mrs. M. became quite thoughtful. She said that, as she listened to the discussion, she realized that she had always handled Tina differently from her other children. The entire family responded to the many crises of adjustment by giving in to Tina's often unreasonable demands and this was now causing other problems. Mrs. M. said she regretted that she had not made better use of the group.

It is questionable whether Mrs. M. could have worked through her feelings to this point if she had not known she was attending the last group meeting. The leader had tried to help Mrs. M. and the other hostile mothers reach some awareness of the group's value so they might be more receptive to accepting group treatment at a later time.

Phases of Development

Most closed, short-term groups go through four distinct phases of development.

Warming Up. The first phase is one of warming up. The group leader and the members begin by feeling each other out. Individual members remain comparatively isolated and their involvement remains superficial. Contact, if any, is of a social nature; group formation is fleeting. Members address their remarks to the leader. Many topics are introduced and discarded. Discussions move haltingly, with more questions and answers than genuine interchanges of ideas.

Gradually, members' involvement with the group increases in depth during the next two or three meetings. Indications of group formation appear. The leader helps the members spell out individual and group goals.

Testing Out. Almost invariably a slump follows. The group seems to fall apart. Members cannot agree on discussion topics. Vague dissatisfactions with the leadership, treatment approach, and goals become apparent, but do not emerge clearly enough for concrete management. At this point the group seems to want to test the leader's authority and skills.

The leader should be prepared for this phase so that he can aid the group in coming to terms with its uncertainties. Although the temptation may be great, it would be premature for the leader to interpret the group's resistance and hostility. At this stage the group would not understand or accept such an interpretation and—with some justification—would relate it to the leader's discomfort.

A calm reassurance that such questioning is part of the normal group process, a quiet acknowledgment that group members may feel uneasy in the beginning, and attention to the topics that emerge in members' comments all stimulate group formation and group processes. The testing phase seldom lasts more than two meetings.

Group Formation. After the slump, group formation should occur. Members should be relaxed and comfortable with each other and with the group leader, whose position is clearly established at this point. As they develop a group focus, members select the problems they want to work on and begin serious therapy. There is observable carryover from one meeting to the next and from the group sessions into the lives of the members.

Ending the Group. The last phase is the preparation for the end of the series of meetings. The leader ushers in this phase during the last two or three meetings. He helps to tie loose ends together by guiding the group through a review of achievements, failures, specific plans that have been developed for individual parents and for the group, and future needs.

There is likely to be separation anxiety on the part of the parents, the leader, or both. The leader must help the group acknowledge such anxiety and handle it appropriately.

By the final session, many parents will be satisfied that the group has provided them with the immediate help they need to handle their lives more adequately. Some parents may want to continue group therapy through another series. The group leader has to be aware of his responsibility toward group members. His professional relationship may not be resolved by the termination of the series and further guidance may be indicated. For example, the leader may feel that a few members need individual followup to round out the group experience. Occasionally, the leader may also refer parents for long-term individual therapy on the basis of problems beyond the framework of the treatment group.

Group Process

Through the group process members learn to maintain themselves within the group and to benefit from their experience without detriment to others. Parents who have been reluctant to acknowledge their child's retardation or cerebral palsy to a therapist may respond quickly and openly to a group, particularly if the group leader and other parents accept the child's condition with equanimity.

Here are a few examples from treatment groups to illustrate group process.

Dynamic Impact of the Group on One Member. One treatment group consisted of mothers who had specific difficulties in adjusting to the knowledge that they had a mentally retarded child. A common factor was that all the mothers had children who attended the clinic at which meetings were held and could arrange their schedules to join the daytime group.

The majority of members had large families, low incomes, and little formal education, but the group included women at almost all levels of the economic and social scales.

Mrs. G. was a socially prominent, highly educated, well-to-do woman whose only child was handicapped. On joining the group, she felt that, because of her background, she had a valuable contribution to make. Her apparent strength soon earned her the role of spokesman. Although she offered good suggestions and recommendations to the other members, she never discussed her own personal problems. At that point it did not occur to her that she would ever receive help from the other mothers.

That she was as vulnerable as the other mothers was brought home to the group through an incident that occurred about halfway through the series. Mrs. L. remarked that her European-born mother-in-law would not accept her grandson's severe retardation and was praying for a miracle. She said, with resignation, "I know that miracles don't happen."

At this point Mrs. G. interrupted her: "But miracles do happen! My daughter came home the other day from school and she could read." Then she burst into tears.

The group responded with a stunned silence. The other mothers had viewed Mrs. G. the way she saw herself—superior, sophisticated, and able to manage her misfortune successfully.

A young, rather dependent mother was greatly affected by the incident. She too became tearful and briefly left the room.

As the group leader, I myself felt somewhat shaken by the degree of exposure of deeply buried emotions and the reactions this could produce in Mrs. G. The next step was obviously mine. I had to respond immediately to the incident and still protect both the group and Mrs. G. without going beyond the treatment possibilities of this group. To focus my attention on the feeling that Mrs. G. had exposed would have been a real ego blow to her, and a likely consequence of such an approach would have been her withdrawal from the group. I therefore chose to focus the discussion on the universal topic of parents' hopes for their children, which somewhat deflected the impact of the incident. The group took it from there.

I was not surprised that Mrs. G. missed the next meeting. I arranged to run into her when she brought her child to the clinic. She said, with some embarrassment: "You don't need hysterical women in your group." I replied that we all have times of tension; now it was time to go on, and I would expect to see her at the next meeting.

No further direct mention was made of the incident to this mother or the group. But having seen Mrs. G.'s vulnerability put the other mothers in a "giving" role. When she returned they rallied around her without being obvious and she became really integrated into the group. For Mrs. G., this experience opened up new approaches to the management of emotional crises and problems and she later made use of it to help herself and others.

Focus on Strengths of Group Members. The importance of emphasizing the strengths rather than the deviations of members can also be illustrated by the mothers' group just described.

One member of the group, Mrs. W., was a lively woman with considerable charm. I saw no need to point out her pathological relationship to her handicapped child, which I knew had heightened many of her difficulties with him. I focused instead on her considerable strengths. The group members remained unaware of her pathology.

Mrs. W. quickly earned the respect and admiration of the other members for keeping her family together during a severe misfortune. The way she posed her problems in the meetings made for good group discussions. Her problems always struck a responsive cord and invoked identification and empathy. This support which she received from the other members brought some changes in her approach to her child, although the basic pathology remained unchanged.

Several times the group had been at the edge of discussion of the possibility of residential care for members' handicapped children, but had always backed away because of discomfort and guilt. In my judgment, the time had not yet come to make the group face its ambivalence about this topic.

Mrs. W., frightened by an incident that had occurred in her family but secure in her standing in the group, broached the subject. She charged that, by refusing to consider residential care to provide training and protection that their handicapped children needed, the mothers might be guilty of neglect. Her comments freed the group members to face the issue that they had skirted so long. They showed considerable relief. Several group members reassessed their children's future and came to decisions about placement in residential institutions as a result of the discussion.

Helping a Participant Withdraw. A different kind of problem arises if, through an error in screening, the group includes a parent who is extremely disruptive or one who feels seriously threatened.

Mrs. B. had a very poor self-image and was striving desperately for status. Her own rather shaky adjustment was threatened by the difficult behavior of an adopted, brain-injured child. She had attended a previous treatment group for parents and was eager to joint the new one that was being formed. When she met the other members of the new group, she jokingly presented herself as a "kind of co-therapist." In her attempts to fill this role as she saw it, she became quite disruptive to the total group process.

She had joined a thoughtful, serious group whose members let silences develop after a discussion of material that strongly affected them. Group contact was never lost during these silences and discussion was resumed easily and naturally.

However, Mrs. B. would become extremely tense during the silences.

After a brief period she would ask a question or try to start a new discussion, thus preventing the group from working through the impact of important or painful material.

When Mrs. B. missed a meeting, I realized how much the group climate changed. Discussions gained in depth and in their meaning to the members. I therefore scheduled an individual appointment with Mrs. B. in an effort to understand her reactions.

She quickly focused on her belief that the group "wasted time" during its quiet periods—time that she said the members should be using to discuss concrete ways of handling their pressing problems. She explained that she had tried to break the silences in order to help the group get back to achieving its goals. Instead of discussing this implied criticism of my leadership, I helped her explore the reasons why the group made her so anxious.

Mrs. B. had a deep-seated fear of revealing her own insecurity to the group. Such a revelation would have been outside the framework of the group and would not have helped either Mrs. B. or the other members. I therefore suggested that she would be more comfortable in individual therapy where she could determine the pace and content of the sessions and get the help she needed. She reacted with considerable relief when I reassured her that I would explain her withdrawal from the group without upsetting the other mothers.

After Mrs. B.'s withdrawal, the group began to pull together, working on their problems at considerable depth.

CONCERNS OF PARENTS

The concerns of parents of handicapped children are not basically different from those of other parents—problems of daily living, management of their families, and handling of their children. But these concerns seem to take on added significance when the child is handicapped. The parents' own hurt about their misfortune, constant worry about their child's medical, physical, and social needs, and the ongoing demands for special care create an emotional climate that colors their reactions to the child and the rest of the family.

Anxiety about a handicapped child's future usually is intense. It is often couched in questions related to the immediacy of child management or discipline—questions about toilet training, eating habits, social opportunities, or sibling relationships, for example. Parents express their concern about finding the right kind of help for their child, his ability to take some responsibility for himself as he grows up, his ability to find satisfaction in spite of his limitations, and the effect of his condition on the rest of the family as he and they get older. There is concern with sexual development and fear of sexual acting out.

The focus changes with the age of the child. It is difficult for the parents of a cute but developmentally handicapped 3-year-old to visualize his as a lumbering teenager who does not speak clearly. Parents whose handicapped child is young are concerned with his physical development. The parents of a school-age child need assistance with appropriate educational planning and help in understanding the child's academic limitations. Still later the parents need help in understanding and adjusting to the adolescent's social and sexual development. They also need guidance in understanding the handicapped youngster's abilities and limitations as a basis for planning an occupation that will permit him some independence.

Even when a highly individualized concern is expressed in the group meeting, the skilled leader will be able to help the group members become aware of aspects that have fairly universal applications.

SUMMARY

In today's complicated society there are many parents who are in need of assistance with sorting out their personal and family reactions to the problems of adjustment to a handicapped child. Few of these parents are interested in a complicated interpretation of the roots of their contradictory feelings. Rather, their needs are for practical, workable ways of meeting the continuing but ever-changing demands of the handicapped child. The closed, short-term group is a particularly effective treatment adjunct in helping these parents.

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